ADVISORY COMMITTEE ON MANAGED HEALTH CARE

MAY 12, 2005, MEETING MINUTES

Cal EPA Building
Coastal Room
1011 I Street
Sacramento, California

Present:

- **Members:** Chairperson Lucinda (Cindy) Ehnes, Angie Wei, Larry Levitt, Tom Davies, Michelle Melden, Elizabeth (Betsy) Imholz, Dr. Morton Field, Dr. Alfred Forrest, Astrid Meghrigian, Steve McDermott.
- **Speaker**: Don Crane
- **Staff:** Warren Barnes, Bill Barcellona, Tina Dunlap, Ellen Badley, Suzanne Chammout, Denise Schmidt
- **Public**: (Approximately 16) Mitchell Zack (John Muir/Mt. Diablo Health Network), Nancy Mikulin, Kristen Martinsen (CalPERS), Beth Edwards (Sutter Health), Agnes Lee (Senate Office Research), S. Beatty (MedImmune), Andrew Gorman (CHA), Misra Nevidita (Kaiser), Deborah Espinal (Kaiser), Dietmar Grellmann (CHA), Leanne Gassaway (CAHP).

1. Advisory Committee Chairperson Cindy Ehnes, Director, Department of Managed Health Care (DMHC), called the meeting to order at 10:15 a.m.

2. Welcome and Introductions – Cindy Ehnes, Committee Chairperson
    - Ms. Ehnes introduced the Committee members.
    - In order to facilitate attendance at meetings, a list of potential quarterly meeting dates were provided to members with a request for an indication of availability.

3. Long Term Implications of the Shift from HMOs (health management organizations) to PPOs (preferred provider organizations) – Don Crane, President and CEO of the California Association of Physician Groups

    Mr. Crane spoke about the trend toward PPOs and whether California can afford it. His presentation was followed by committee discussion of the issues.

4. Committee Discussion of Recommendations for Improving the Health Care Delivery System and Quality of Care – Cindy Ehnes, Committee Chairperson

Ms. Ehnes led the Committee in a discussion of some of their suggestions for improving California's health care delivery system and quality of care. No vote was taken, but those Committee members present offered and discussed the following suggestions:

- Support the concept of universal care in a way that improves care. Create a benefit package that is better than mandated packages – including preventive care, discretionary items, and price competition at the provider level.
- California is the only state that bifurcates regulation -- combine the Department of Insurance (DOI) and DMHC.
- Encourage collaboration between the DOI and the DMHC to respect and clarify their separate domains of purpose and expertise consistently with their separate and distinct legislative frameworks. The intent would be to assure consistency, thereby leveling the playing filed between HMOs and insurers, and to discourage "regulatory forum shopping" by health plans. For example, the DOI might take on responsibility for setting the standards of coverage for mandated benefits, which would be accepted and implemented by DMHC for HMOs. On the other hand, the DMHC might regulate and set the standards to be used by both departments with respect to provider contracting.
- Develop an agreed-upon set of guiding principles, values, or criteria, as touchstones or reference points in considering any legislative or regulatory action, dealing with such topics as access, quality, choice, coverage, value, shared accountability, and cost, among others, for group purchasers, health plans, providers, and consumers.
- Within the framework of guiding principles, identify specific deficiencies and perverse incentives in current systems of financing and delivering health care, and use the platform of the Advisory Committee to expose them to the sanitizing light of day with the express intention of creating a public agenda for dealing with them.
- The Committee (or the DMHC) should explore ways of being more prescriptive in their oversight of managed care plans relative to the public interest; need to assure that financing of health care is focused not just on cost alone, but also on the quality of care provided by network providers.
- The existence of the Committee affords an unusual opportunity that should be exploited, to create an ongoing public forum for structured discourse and debate of public policy health issues within the Committee itself, but also including broader input through public testimony and commentary. If the Committee makes enough noise, perhaps others will listen.
- California is not on the cutting edge. Re-think the Knox-Keene Act and restore quality of care.
- Create a framework on the front end -- then consider how and who. Product designs must provide greater access – and must not rely on

underwriting or deductibles. There is not enough latitude in the current system.

- Lead a public dialogue on the California "health eco-system" heading toward crisis. HMO-style insurance cannot be viewed in isolation from the pieces of the health system that affect it, such as the key cost drivers of hospital costs and prescription drugs. Hospital closings and nursing and provider shortages mean that ensuring Knox-Keene's promise of "adequacy of network" may not remain feasible. In addition, as the Little Hoover Commission found not long ago, our public health infrastructure is not adequate to ensure the public protection from environmental contamination, disease, and infection. California needs a focused commitment of overall health care planning to ensure these core governmental functions are met. The Cost Containment Commission called for by SB 2 would be one forum for attempting to address the key issues of access, cost, and quality in California.
- Address high-deductible and other high-share-of-cost insurance issues. Skimpy policies in the long term will compound systemic cost pressures, while also creating personal hardship for California families.
- Individual market reform is needed. For those without employer coverage, cherry picking by insurers means that those with the greatest medical need may find it hardest to get a policy. Two key issues here are exclusions for pre-existing conditions and high cost.
- Support patient safety reforms, including adequate funding and regulatory revisions to the Medical Board that oversees physician performance and hospital licensing and outcome disclosure functions, including on hospital-acquired infections at the Office of Statewide Health Planning and Development and the Department of Health Services.
- Support meaningful regulatory reforms of discount health plans. As cost pressures on consumers increase, the pitfalls presented by misrepresentation of discounts by some health plans also grow. This longstanding issue warrants attention in the coming year.

Members of the public attending the meeting offered the following suggestions:

- Innovation in health care products – health care costs have continued to rise year after year and are finally slowing down as plans institute new innovative ideas. DMHC and DOI's support of emerging plan designs such as consumer-directed health plans and HMO deductible products is encouraging. These product designs will infuse a new set of managed care tools and consumer empowerment to control costs, instead of heavy-handed oversight and dictation of care. Also, there is a need to capitalize on the tax-deductibility afforded by federal government and replicate that tax savings at the state level so that consumers can take full advantage of the new health savings account opportunities. Create a collaboration of business and labor to work together to contain costs of uncompensated care.

- Threats to the contracted environment – health plans and providers are mutually dependent on one another and there are threats in the current environment to keeping this fabric together. The current discussions underway between the California Medical Association, California Healthcare Association, California Association of Physician Groups, and the California Association of Health Plans are helpful in finding common ground and working out issues through discussion (facilitated by the DMHC). Continuing to add administrative burden on capitated providers is going to start making them think twice about the value of contracting with health plans on a capitated basis.
- Reduce unnecessary costs, particularly administrative costs. The DMHC should strive to streamline administrative processes, such as financial audits, medical surveys, and other routine regulatory activities that may be duplicative or wasteful of precious resources. The recommendation in the California Performance Review regarding the National Committee on Quality Assurance's deeming for certain types of medical survey elements is encouraging. The DMHC should evaluate streamlining certain parts of the financial audit that are highly duplicative to the Sarbanes Oxley requirements. There should be an evaluation of the various reporting requirements that are requested today as to their value and usefulness. Don't just report for the sake of reporting. Data calls to the industry should be relevant and useful to the DMHC's oversight and evaluation of plan compliance with the Knox Keene Act.
- Promote evidence-based medicine and disease management.
- Avoid preventable disease and injury (i.e. obesity). Stakeholders are collaborating with each other and especially with the clinical community on how to stop the obesity epidemic to improve the health of members. Obesity will kill more people than smoking. It was reported that children today are the first generation that will not live longer than their parents.

Additional written comments submitted prior to the meeting by Committee members and the public were provided to the Committee, but not discussed.

The meeting adjourned at 12:15.